FORM 1

MEDICINE

Web

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

DEPARTMENT USE ONLY

60

735 ER

APPLICATION FOR LICENSE AND FIRST REGISTRATION

1 SOCIAL SECURITY NUMBER: [redacted]
(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE: 11 18 76
mo. day yr.

3 PRINT FULL NAME AS YOU WISH IT TO APPEAR ON YOUR LICENSE:

Last TSITLAKIDIS
First CONSTANTINA
Middle

NYS License Number 228515 5-27-03

4 MAILING ADDRESS CHECK ONE: ☒ HOME ADDRESS ☐ WORK ADDRESS

Care of CONSTANTINA TSITLAKIDI
Street [redacted]
City ASTORIA
State NY Zip Code [redacted]
Province/Country If not U.S.

The above address is: ☒ permanent address of record ☐ temporary mailing address

IMPORTANT: The applicant is responsible for notifying the Department of any name or address changes.

5 TELEPHONE

HOME [redacted]
Area Code Number

WORK [redacted]
Area Code Number

[redacted]
E-Mail Address

6 Name as it appears on diploma or other credentials (if different from above): _____

7 Citizenship: ☒ United States ☐ Alien lawfully admitted for permanent residence in the United States. (Attach a copy of the front and back of the alien registration card) ☐ Other Immigration _____

8 Mother's Maiden Name *(family name before her marriage)*: DELIANIDIS

9 I wish to become licensed on the basis of: ☒ acceptable examination scores *(see page 3 of this form)* ☐ endorsement of another license *(See Pg. 11.)*

I am using FCVS to collect my credentials: ☐ YES ☐ NO

10 Have you previously applied for a New York State license or a limited permit to practice medicine? ☐ YES ☒ NO

11 Have you ever been convicted of a crime (felony or misdemeanor) in any state or country? [redacted]

12 Have you ever been charged with a crime (felony or misdemeanor) in any state or country, the disposition of which was other than by acquittal or dismissal? [redacted]

13 Have you ever surrendered your license or been found guilty of professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? [redacted]

14 Are charges pending against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? [redacted]

15 Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures ? [redacted]

NOTE: If any answer to any question 11-15 is "Yes," submit a letter giving complete explanation. Include copies of any court records, and if you possess one, a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

16 In the space below, give a complete record of your education preparation. Attach additional sheets if necessary.

SCHOOLS ATTENDED AND LOCATION (including country) List schools in original language and translate.	Number of Years Attended	Diploma or Degree Obtained *List diploma or degree titles in original language and translate. Indicate year obtained*	If no diploma or degree, number of credits earned
High School or Secondary William Cullen Bryant High School 48-10 31st AVE L.I.C, 11103 U.S.A.	3	H.S. Diploma 1993	
Postsecondary Preprofessional (Exclusive of Medical School) City College, CUNY MEDICAL SCHOOL. THE SOPHIE DAVIS SCHOOL of BIOMEDICAL EDUCATION, 138th St Convent Avenue, N.Y, N.Y. 10031	5	Bachelor of Science, 1998	
Medical Education (Professional) (List all medical schools attended) NEW YORK MEDICAL COLLEGE, VALHALLA, N.Y. 10595	2	DOCTOR of MEDICINE, 2000	

17 If you completed clinical clerkships in a country other than where your medical school is located, give the dates and location of these clerkships. Attach additional sheets if necessary.

Inclusive Clerkship Dates	Clinical Area	Name of Health Care Facility And Address	Medical School with which Clerkship Affiliated and Address

18 Provide a chronological list of all activities since graduation from professional school to the present. Include vacation periods and periods of employment. Attach additional sheets if necessary.

DATE (mm/dd/yy) From	DATE (mm/dd/yy) To	Type of Activity, Beginning with Date of Graduation from Professional School. Include Name and Address of Employers.
05/19/00	06/30/00	VACATION
07/01/00	12/30/00	LONG ISLAND JEWISH MEDICAL CENTER, PGY-I, 270-05 76th AVE, NEW HYDE PARK, N.Y. 11040
01/01/01	01/31/01	VACATION
02/01/01	07/31/01	LONG ISLAND JEWISH MEDICAL CENTER, PGY-I - PGY-II, 270-05 76th AVE, NEW HYDE PARK, N.Y. 11040
08/01/01	08/15/01	VACATION
08/16/01	01/01/02	LONG ISLAND JEWISH MEDICAL CENTER PGY-II, 270-05 76th AVE, NEW HYDE PARK, N.Y. 11040
01/02/02	01/16/02	VACATION
01/17/02	08/28/02	LONG ISLAND JEWISH MEDICAL CENTER PGY-II, PGY-III, 270-05 76th AVE, NEW HYDE PARK, N.Y. 11040
08/29/02	09/11/02	VACATION

19 **Complete item 19 only if you are a graduate of a program not registered by New York State or LCME or AOA accredited.**

Have you completed all portions of the examination requirements for ECFMG certification? ☐ Yes ☐ No

Do you currently hold a valid ECFMG certificate? ☐ Yes ☐ No

Please complete and forward the ECFMG form enclosed with this application packet.

20 Are you applying for licensure on the basis of a Fifth Pathway program? ☐ Yes ☒ No

If Yes, list name and location of medical school or hospital and the inclusive dates of attendance.

Name and Location of Medical School or Hospital	Inclusive Dates of Attendance

21 List in English, all specialty qualifications you have earned. (i.e., Board Specialty Certification or Diplomate Certificate)

Name of Qualifications	Name and location of organization issuing credential

22 ☐ I will be applying for USMLE Step 3

OR

☒ I have successfully completed the examination combination indicated below:

EXAMINATION COMBINATIONS

- ☒ USMLE Steps 1, 2, and 3
- ☐ FLEX Parts I, II, and III
- ☐ FLEX Components I and II
- ☐ NBME Parts I, II, and III
- ☐ NBME Parts I and II and USMLE Step 3
- ☐ NBME Part I, USMLE Step 2 and NBME Part III
- ☐ NBME Part I, and USMLE Steps 2 and 3
- ☐ USMLE Step 1, and NBME Parts II and III
- ☐ USMLE Step 1, NBME Part II, and USMLE Step 3
- ☐ USMLE Steps 1 and 2 and NBME Part III
- ☐ USMLE Step 1, NBME Part II, and FLEX Component II
- ☐ NBME Part I, USMLE Step 2, and FLEX Component II
- ☐ USMLE Steps 1 and 2 and FLEX Component II
- ☐ NBME Parts I and II and FLEX Component II
- ☐ FLEX Component I and USMLE Step 3
- ☐ NBOME Parts I, II, and III
- ☐ Other: _____

Date examination sequence was completed 07/26/02

23 Are you licensed or have you ever been licensed as a physician in any other state or country? ☐ Yes ☒ No

If **yes**, list each jurisdiction. In addition, you must have a Form 3A or 3B, as appropriate, submitted. See pages 14 - 15.

State or Country	Date License Issued	Number	Basis of Licensure			Any Limitations on License
			Examination (Date passed)	Endorsement	Other	

24 If you hold a New York State license in another profession, indicate the profession, your license number and date of licensure below.

Profession	License Number	Date of Initial Licensure (mm/dd/yy)
		/ /
		/ /
		/ /
		/ /

25 **CHILD SUPPORT OBLIGATION:**

New York State General Obligations Law, section 3-503, requires every applicant for a professional license, permit, or registration, or any renewal there of, to file a written statement that, as of the date of the filing, he or she is, or is not, under an obligation to pay child support. **Individuals who are four months or more in arrears in child support may be subject to suspension of their business, professional and/or drivers licenses.** The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable pursuant to section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are under an obligation to pay child support but are not in compliance with the General Obligations Law can be issued a credential for no more than six months to discharge child support obligations consistent with that law.

Check only A or B below. If you check B, you must check one of the five statements listed below it.

A ☒ I am **not** under an obligation to pay child support:

OR

B ☐ I am under an obligation to pay child support *and* (please check only one of the following)

- ☐ I am current and **am not** four months or more in arrears in the payment of child support: or,
- ☐ I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,
- ☐ The child support obligation is the subject of a pending court proceeding; or,
- ☐ I am receiving public assistance or supplemental security income; or,
- ☐ None of the above four statements apply.

26 STUDENT LOAN DISCLOSURE:

(a) Do you have any outstanding loans made or guaranteed by the New York State Higher Education Services Corporation? ☐ Yes ☒ No

(b) If you have such a loan(s), is any part in default? ☐ Yes ☐ No

NOTE: Education Law (Section 6501-a) requires the State Education Department to ask the questions above and forward any "yes" responses to question (b) to the New York State Higher Education Services Corporation. **Your license application is not complete without this information.**

27 GENDER AND ETHNICITY: (This item is optional. See note below.)

NOTE: Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning representation in the licensed professions. The ethnic and gender data you provide will be used only for statistical research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

ETHNICITY: ☒ White (not Hispanic) ☐ Black (not Hispanic) ☐ Asian ☐ Hispanic ☐ Native American

GENDER: ☐ Male ☒ Female

28 CHILD ABUSE IDENTIFICATION AND REPORTING: (check only one of the following.)

☒ I graduated from a New York State medicine program after September 1, 1987.

☐ I completed the child abuse coursework and have enclosed a certificate of completion from an approved provider.

☐ I am filing for an exemption to the requirement and have enclosed the exemption form.

29 PHOTOGRAPH REQUIREMENT:

I give permission to the New York State Education Department to release my examination results to my professional school for the confidential purposes of program review and institution research and planning. I may rescind this authority at any time by notifying, in writing, the Division of Professional Licensing Services.

☒ Yes ☐ No Please initial: _____

Under penalties of perjury, I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in connection with my application may be cause for denial or loss of licensure.

Signature of applicant: _____ Date: 5/24/03

Date of photo: 1/03

ANGELA A. ISSA
Notary Public, State of New York
No. 01IS5014981
Qualified in Queens County
Commission Expires 2/5/12

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, Fee Section, Division of Professional Licensing Services 89 Washington Avenue, Albany, NY 12234-1000. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.

FORM 2

MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

CERTIFICATION OF PROFESSIONAL AND PREPROFESSIONAL EDUCATION

APPLICANT INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your New York State Licensure Application (Form 1).
2. Send this form to the professional school you attended to complete Section II. Be sure to include any fee required. If you graduated from a medical school that was not registered by New York State or accredited by LCME/AOA, notify the school that a transcript must accompany this form.
3. If you attended a medical school that has been closed, send this form to the official repository of the records for that school (e.g., CONES).
4. This form must be signed by the Registrar, Dean, Rector, or Principal of the medical school and sent back directly to the Office of the Professions by that school official in an official school envelope. Forms sent back by the applicant or other parties will not be accepted.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER [redacted]
Applicants Must Furnish Their U.S. Social Security Number

2 BIRTH DATE [redacted]
Month Day Year

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR LICENSURE APPLICATION (FORM 1)

Last: TSITLAIDIS
First: CONSTANTINA
Middle:
Maiden or Previous name:

4 MAILING ADDRESS

Apt./Bldg.: 41-10 DITMARS BLVD
Street:
City: ASTORIA
State: NY Zip Code: 11105
Province/County if not U.S.:

(Check one only) ☒ permanent address of record ☐ temporary mailing address until

5 TELEPHONE: WORK 718-470-7700 (Area Code Number) HOME 718-726-6527 (Area Code Number)

6 Print name under which your degree or diploma was awarded (if different from above):

7 Preprofessional School Attended: City College, CUNY MEDICAL SCHOOL-THE SOPHIE DAVIS SCHOOL OF BIOMEDICAL EDUCATION

8 Professional School Attended: NEW YORK MEDICAL COLLEGE
Address: Administration Bldg, VALHALLA, N.Y. 10595

9 Name of Degree/Diploma: B.S. / M.D. Date awarded: 1995 / 2000

SECTION II : CERTIFICATION OF PROFESSIONAL

INSTRUCTION TO SCHOOL: Please complete this section, sign certifying statement, attach the information in Item 5 and send directly to the Office of the Professions at the address shown below. **This form will not be accepted if returned by the applicant or any other party.**

1 Applicant's Entrance date: 07 / 06 / 1998 Completion/Withdrawal Date: 05 / 19 / 2000

2 Degree/diploma conferred: Doctor of Medicine Date of conferral: 05 / 19 / 2000

3 Did the applicant receive advanced standing based on prior academic work? ☑ YES ☐ NO
If Yes, indicate when the prior work was completed below.

Name of Institution: CCNY Sophie Davis School of Bio-Med Dates of attendance: 1993 to 1998

Submit with this form: (1) An official transcript of studies at your institution, and
(2) Copies of documentation in your file to support the granting of transfer credit.

4 ***For Applicants from N.Y.S. Registered or LCME/AOA Accredited Medical Schools:***

Applicant met LCME/AOA requirements for admission to medical/osteopathic school? ☒ YES ☐ NO

If No, number of preprofessional postsecondary credit hours completed by applicant prior to admission to medical school _____ semester hours or _____ quarter hours.

5 ***For All Other Applicants:***

Years of education required for admission into your medical school: _____

Preprofessional credential/degree submitted by applicant for admission into your medical school: _____

Was Social Service required? ☐ YES ☐ NO If Yes, give inclusive dates and name of institution in which requirement was met.

Institution: _____ Dates: _____ to _____

Was a pre-graduation internship required? ☐ YES ☐ NO If Yes, give inclusive dates and name of institution in which requirement was met.

Institution: _____ Dates: _____ to _____

Submit with this form:

A. An official transcript (course record, index, or marksheets) showing courses taken at your institution and accepted from other institutions for transfer of credit of convalidation.
The transcript must bear the original signature of the dean, principal, rector, or registrar and original seal of the school.

B. A copy of documentation from your files to support the granting of transfer credit or convalidated course and clerkships.

C. List of clinical clerkship completed outside jurisdiction where medical school is located, including (for each): area or specialty, starting and ending dates of clerkship, and name and address of hospital where clerkship was performed.

FOR ATTENDEES OF CIFAS, CETEC, AND UTESA, this list must include all clerkships completed, both inside and outside the jurisdiction where the medical school is/was located.

I certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the individual named on this form.

Signature: [signature]

Type or Print Name: Judith A. Ehren

Title: University Registrar

Medical School: New York Medical College (SEAL)

Address: Sunshine Cottage, Office of the Registrar
Valhalla, New York 10595

Telephone: (914)594-4495 *E-mail address:* _____

Date: 03 / 28 / 2003

CERTIFICATION IS NOT ACCEPTABLE UNLESS DATED AFTER GRADUATION.

Return this Form and material requested above to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Licensing Unit, 89 Washington Avenue, Albany, NY 12234-1000.

FORM 2PGT

MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

Certification of completion o approved postgraduate trainin will be accepted only if it is signe no more than one month prior t the completion date of the trainin period in which credit is sought.

CERTIFICATION OF APPROVED POSTGRADUATE TRAINING

(To be used only for U.S. and Canadian approved postgraduate training programs)

APPLICANT INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your Licensure Application (Form 1).
2. Please send this form to the director of medical education of the medical facility at which you completed postgraduate training. One form must be submitted to verify each residency. If you have completed more than one residency, you may photocopy this form.
3. This form must be sent directly to the Department by the hospital in which you did your residency. If the hospital in which you did your residency does not have a director of medical education, the forms may be completed by the department chair. If the Department cannot determine that this verification came directly from the hospital, the postgraduate hospital training will not be credited.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER [redacted]
(Leave this blank if your number is Social Security Number)

2 BIRTH DATE: 11 18 75
Month Day Year

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR APPLICATION (FORM 1)

Last: TSITLAKIDES
First: JONSTANTINA
Middle:

4 MAILING ADDRESS:
Apt No: 411-10 DITMARS BLVD
Street: ASTORIA
City: ASTORIA
State: N.Y. Zip Code: 11105
Province Country if not U.S.:

5 Print name under which postgraduate training was completed: CONSTANTINA TSITLAKIDIS

6 Hospital in which postgraduate training was completed: LONG ISLAND JEWISH MEDICAL CENTER
Address: 270-05 76TH AVE, NEW HYDE PARK, N.Y. 11040

SECTION II : CERTIFICATION OF POSTGRADUATE TRAINING

INSTRUCTION TO HOSPITAL: Please complete this section, sign certifying statement, and return the form *directly* to the Division of Professional Licensing Services at the address shown below. **This form will not be accepted if returned by the applicant.**

This is to certify that Constantina Tsitlakidis
(Physician's Name)

a graduate of New York Medical College
(Medical school)

was enrolled in a postgraduate training program(s) approved by the Accreditation Council on Graduate Medical Education, the American Osteopathic Association, or Royal College of Physicians and Surgeons of Canada at

Long Island Jewish Medical Center
(Name and location of Hospital)

Level of Training (example PGY-1)	Clinical Area	Inclusive dates (mm/dd/yy)	Successfully completed
PGY-1	Internal Medicine	7/01/00 to 6/30/01	☑ YES ☐ NO ☐ In progress; satisfactory to date
PGY-2	Internal Medicine	7/01/01 to 6/30/02	☑ YES ☐ NO ☐ In progress; satisfactory to date
PGY-3	Internal Medicine	7/1/02 to 6/30/03	☐ YES ☐ NO ☐ In progress; satisfactory to date
		___/___/___ to ___/___/___	☐ YES ☐ NO ☐ In progress; satisfactory to date
		___/___/___ to ___/___/___	☐ YES ☐ NO ☐ In progress; satisfactory to date

If this physician did not successfully complete the postgraduate training program, please attach a letter of explanation with this form.

☐ Explanation is attached

I am the director of medical education or department chair of the clinical area. I was the program director for the physician named above during the postgraduate training indicated and have carefully read and completed this form and hereby attest that the statements made herein are strictly true in every respect and are supported by hospital records.

Signature of Director/Chair: [signature]

Type or Print Name of Director/Chair: Cindy Baskin, MD

Title or Official position: Associate Program Director

Institution: LIJ MEDICAL CENTER

Address: 270-05 76th AVE
NEW HYDE PARK, NY 11040

(SEAL)

Telephone: (718) 470 4460 Date: 4/8/03

E-mail Address: CBaskin@lij.edu

Return this Form to: New York State Education Department, Office of the Professions. Division of Professional Licensing Services, Medicine Licensing Unit, 89 Washington Avenue, Albany, NY 12234-1000.

228515TSI5004580060105

REGISTRATION RENEWAL DOCUMENT

THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

12/01/04
ID 228515
NME TSI5
CD 05
OFF 1
EFN

TSITLAKIDIS CONSTANTINA
41-10 DITMARS BLVD
ASTORIA NY 11105-0000

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

PROFESSION 60 MEDICINE
PERIOD 05/01/05 - 10/31/06

$ 458
AMOUNT DUE

Complete and sign reverse side of this application

1. Do you wish to register for the period indicated? ✓ Yes ___ No

2. Since your last registration application,
   a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? ✓ No
   b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? ✓ No
   c. Are criminal charges pending against you in any court? ✓ No
   d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? ✓ No
   e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? ✓ No

3. a. Are you under an obligation to pay child support? ___ Yes ✓ No
   b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? N/A ___ Yes ___ No

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.? ✓ Yes ___ No

[redacted]

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution and** may be cause for disciplinary action, including the loss of my license, and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [signature] Daytime phone (917) 670-7244 Date 3/6/05

228515TSI506000060106

REGISTRATION RENEWAL DOCUMENT

THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

06/01/06
LIC. 228515
NME TSI5
YR 06
OFF: 1
FIN:

TSITLAKIDIS CONSTANTINA
41-10 DITMARS BLVD
ASTORIA NY 11105-0000

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

PROFESSION: 60 MEDICINE
PERIOD: 11/01/06 - 10/31/08

$ 600
AMOUNT DUE

Cat 21: 03204

Complete and sign reverse side of this application

1. Do you wish to register for the period indicated? ..... [X] Yes [ ] No

2. Since your last registration application,

a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? ..... [redacted]

b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? .....

c. Are criminal charges pending against you in any court? .....

d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? .....

e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? .....

3. a. Are you under an obligation to pay child support? ..... [ ] Yes [X] No

b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? ..... [ ] Yes [ ] No

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.? ..... [X] Yes [ ] No

S2449253 [illegible]
129 08182006

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution and** may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [signature] Daytime phone (718) 926-6325 Date 8/15/06

Cal216:110705

228515TSI5006000060108

REGISTRATION RENEWAL DOCUMENT

THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

06/02/08
LIC: 228515
NML: TSI5
YR: 08
OPT: 1
EIN:

TSITLAKIDIS CONSTANTINA
41-10 DITMARS BLVD
ASTORIA NY 11105-0000

PIN: QW51522

PROFESSION: 60 MEDICINE
PERIOD: 11/01/08 - 10/31/10

Complete and sign reverse side of this application

Ed 21 00406

Address change
Complete only if change has occurred

24-12 36th Street
Street
Astor. 4
City
N.Y. 11103
State/Zip

$ 500
AMOUNT DUE

1. Do you wish to register for the period indicated? . . . . ✓ Yes __ No

2. Since your last registration application,

a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? . . . . [redacted] ✓ No

b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? ✓ No

c. Are criminal charges pending against you in any court? . . . . ✓ No

d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? . . . . ✓ No

e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? . . . . ✓ No

3. a. Are you under an obligation to pay child support? . . . . __ Yes ✓ No

b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? . . . . __ Yes ✓ No N/A

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.? . . . . ✓ Yes __ No

[illegible]
[illegible]

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution and** may be cause for disciplinary action, including the loss of my license, and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [signature] Daytime phone (917) 670-7244 Date 9/20/08

Cat.18 10/02

OFFICE OF THE PROFESSIONS

89 Washington Avenue
Albany, NY 12234
518-474-3817

Registration Renewal - Transaction Summary

License Number : 228515
Profession : MEDICINE
Renewal Period : 11/01/2010 through 10/31/2012

We recommend that you print and keep this transaction summary. Thank you for using OP Registration Online.

TSITLAKIDIS CONSTANTINA
24-12 36TH STREET
ASTORIA NY 11103 - 0000

Renewal Status : **Paid On-line - Renewal Complete**

Offices Selected for Renewal:

	Address	Fee
1)	24-12 36TH STREET, ASTORIA, NY, 11103,US	$ 600

Response to Questions :

Question	Response
1) Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	No
2) Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	No
3) Are criminal charges pending against you in any court?	No
4) Are charges pending against you in any jurisdiction for any sort of professional misconduct?	No
5) Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?	No
6) Are you under an obligation to pay child support?	No
7) Are you a U.S. citizen?	Yes

License Renewal Payment Details:

Receipt No	VRFN5DF02C5C
Payment Date	08/19/2010
Amount Paid	$ 600

OP

89 Washington Avenue
Albany, NY 12234
518-474-3817

Confirmation Number: 228515
Profession: MED CINE
Registration Period: 11/01/2010 through 10/31/2012

We recommend that you print and keep this transaction summary. Thank you for using OP Registration Online.

TSITLAKIDIS CONSTANTINA
24-12 36TH STREET
ASTORIA NY 11103 - 0000

Transaction Status: Paid On-line - Renewal Complete

Offices Selected for Renewal:

	Address	Fee
1	24-12 36TH STREET, ASTORIA, NY 11103,US	$ 600

Response to Questions:

	Question	Response
1	Have you been convicted, adjudged guilty after trial, or pleaded guilty, no contest or nolo contendere to a crime, felony or misdemeanor in any court?	No
2	Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	No
3	Are criminal charges pending against you in any court?	No
4	Are charges pending against you in any jurisdiction for any sort of professional misconduct?	No
5	Has any hospital, licensed facility, restricted or terminated your professional training, employment, or privileges or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetence, or negligence?	No
6	Are you under an obligation to pay child support?	No
7	Are you a U.S. citizen?	Yes

License Renewal Payment Details:

Order No:	VRENBDF02CGC
Payment Date:	08/19/2010
Amount:	$ 600

OFFICE OF THE PROFESSIONS

Registration Renewal - Transaction Summary

89 Washington Avenue
Albany, NY 12234
518-474-3817

License Number : 228515
Profession : MEDICINE
Renewal Period : 11/01/2012 through 10/31/2014

We recommend that you print and keep this transaction summary. Thank you for using OP Registration Online.

TSITLAKIDIS CONSTANTINA
24-12 96TH STREET
ASTORIA NY 11103-0000

Renewal Status **Paid On-line - Renewal Complete**

Offices Selected for Renewal:

	Address	Fee
1)	24-12 96TH STREET, ASTORIA, NY, 11103,US	$ 600

Response to Questions :

Question	Response
1) Have you been found guilty after trial, or pleaded guilty, no contest or nolo contendere to a crime (felony or misdemeanor) in any court?	No
2) Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	No
3) Are criminal charges pending against you in any court?	No
4) Are charges pending against you in any jurisdiction for any sort of professional misconduct?	No
5) Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?	No
6) Are you under an obligation to pay child support?	No
7) Are you a U.S. citizen?	Yes

License Renewal Payment Details:

Receipt No	:4642847674
Payment Date	:09/13/2012
Amount Paid	:$ 600

OP

89 Washington Avenue
Albany, NY 12234
518-474-3817

	278515
	MEDICINE
	11/01/2012 through 10/31/2014

We recommend that you print and keep this transaction summary. Thank you for using OP Registration Online.

ESTEAKIDIS CONSTANTINA
24-12 36TH STREET
ASTORIA NY 11103 - 0000

Paid On-line - Renewal Complete

Offices Selected for Renewal

	Address	Fee
1.	24-12 36TH STREET, ASTORIA, NY, 11103,US	$ 600

Responses to Questions

	Question	Response
1	Have you been found guilty after trial or pleaded guilty, no contest or nolo contendere to a crime (felony or misdemeanor) in any court?	No
2	Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	No
3	Are criminal charges pending against you in any court?	No
4	Are charges pending against you in any jurisdiction for any sort of professional misconduct?	No
5	Has any hospital or licensed facility restricted or terminated your professional training, employment or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such act on due to professional misconduct, unprofessional conduct, incompetency or negligence?	No
6	Are you under an obligation to pay child support?	No
	Are you a U.S. citizen?	Yes

License Renewal Payment Details:

	654784[illegible]4
	09/13/2012
	$ 600